MINUTES
of the
FOURTH MEETING
of the
BEHAVIORAL HEALTH SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

November 5, 2013
Room 322, State Capitol
Santa Fe

The fourth meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee was called to order by Senator Benny Shendo, Jr., chair, on November 5, 2013 at 8:40 a.m. in Room 322 of the State Capitol in Santa Fe.

Present
Sen. Benny Shendo, Jr., Chair
Sen. Sue Wilson Beffort
Sen. Craig W. Brandt
Rep. Sandra D. Jeff
Sen. Howie C. Morales
Sen. Bill B. O'Neill
Sen. Gerald Ortiz y Pino
Sen. Mary Kay Papen
Sen. Sander Rue
Rep. Edward C. Sandoval

Absent
Rep. Phillip M. Archuleta, Vice Chair
Rep. Paul A. Pacheco

Guest Legislators
Rep. David M. Gallegos
Rep. Miguel P. Garcia
Rep. James Roger Madalena
Sen. Nancy Rodriguez
Rep. Elizabeth "Liz" Thomson

Staff
Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Michael Hely, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS
Nancy Ellis, LCS
Branden Ibarra, LCS

Guests
The guest list is in the meeting file.

Handouts

Copies of handouts and other written testimony are in the meeting file.

Tuesday, November 5

Welcome and Introductions

Senator Shendo welcomed attendees and asked members of the subcommittee and LCS staff to introduce themselves.

Updates from State Auditor and Attorney General (AG) on Behavioral Health Matters

Hector H. Balderas, state auditor, provided a written response (see handout) to members regarding their July 15, 2013 letter inquiring about the financial affairs and transactions of the Human Services Department (HSD), its Behavioral Health Services Division (BHSD) and the Interagency Behavioral Health Purchasing Collaborative. The letter asked the state auditor to answer specific questions in connection with the Medicaid payment holds placed by the HSD on 15 behavioral health providers following an audit performed by the Public Consulting Group, Inc. (PCG).

Mr. Balderas briefly reviewed the state auditor's jurisdiction and involvement and said that as part of this process, his staff auditors are currently working closely with the independent auditor who is conducting the HSD's annual financial audit. Due to the HSD's significant expenditure of federal funds, Mr. Balderas said, his independent auditors are required by federal law to test and report whether the HSD has adequate procedures in place to identify fraud and safeguard federal funds. Consequently, his auditors are required to test whether the HSD has established and implemented procedures to safeguard against unnecessary utilization of care and services, and it is within this context that it was necessary for his auditors to review and analyze the PCG audit report.

In a review of his efforts to obtain the PCG audit, Mr. Balderas described the court-ordered subpoena to the HSD to produce all audit reports and to cooperate fully with his office. Since receipt of that report, his office has requested and received numerous additional documents and information from the HSD, Mr. Balderas said, and his auditors have been in frequent contact with the federal Centers for Medicare and Medicaid Services (CMS) for guidance on proper verification of credible allegations of fraud. Further, he said, his auditors have been in communication with PCG to discuss in more detail the process that PCG used to plan and conduct the audit, including PCG's analysis and extrapolation methodology as they relate to the HSD's verification process.

Mr. Balderas said that as part of this fiscal year's audit process, his staff thoroughly assessed and evaluated each question in the subcommittee's July 15 letter, but because the audit has not yet concluded, he was unable to provide detailed answers that day. Certain of the questions outlined in the subcommittee's letter appear to fall outside the state auditor's jurisdiction, he said, and may require separate engagement outside of the HSD's financial audit to

get meaningful answers. A comprehensive and detailed response to each question will be provided once the financial audit is complete. Barring any unforseen circumstances, Mr. Balderas expects the HSD financial audit report to be submitted to his office no later than December 16, 2013. Once the audit report is publicly available, Mr. Balderas said, he would immediately transmit a copy to the Behavioral Health Subcommittee and provide an update to its July 15, 2013 queries.

Questions/Concerns

Subcommittee members had numerous questions for Mr. Balderas and for Chief Deputy AG Albert J. Lama, who was present to discuss the separate investigation of his office into allegations of fraud among the 15 behavioral health service provider agencies.

The *HSD's settlement with two providers that repaid the state $4.2 million for alleged improper billings*. A member asked if these recently announced payments would apply to any fraud findings by the AG. Mr. Lama said that the HSD settlement with the two providers would not have any impact on the AG's investigation. Credible allegation of fraud was a determination made by the HSD; the AG's investigation will determine if there was actual civil or criminal fraud. Another member asked why all 15 of the suspended providers could not have been afforded the same opportunity. Mr. Lama said he could not speculate on why the HSD chose to reinstate these two providers. Asked if the two reinstated providers (Presbyterian Medical Services and Youth Development, Inc.) would still be under investigation, Mr. Lama said yes, the AG's process is independent from the HSD's process.

Time frame for results of the AG's investigation. Mr. Lama described the resources his office has dedicated to this investigation: 16 individuals on the team, including two investigators from the Federal Bureau of Investigation (FBI), who have been divided into three smaller teams that meet weekly. The 15 providers also have been divided into groups assigned to each team. Data collection has been extensive, Mr. Lama said, involving literally hundreds of thousands of documents. The investigative team also includes three certified data collectors (one from the FBI) who started work in July. The teams have received good cooperation from the HSD, he said. What the teams are looking for is very specific information. When the PCG audit identified "irregular billing practices", Mr. Lama said, that does not necessarily indicate that there is civil or criminal action; it might indicate a technical issue. He said he could not yet give a specific date for completion of the investigation.

A member asked Mr. Balderas for the name of the firm conducting the independent audit of the HSD. It is Clifton Morris, Mr. Balderas said, and this is that firm's second year of conducting the annual HSD audit.

Mr. Balderas said that there is an opportunity to make improvements in the detection of fraud throughout state government, and his office may come forth with some "best practices". There could be increased training about detecting fraud and possibly some regulatory or statutory changes to help bring about increased oversight.

Public Comment

Hannah Leigh Bull is a behavioral health provider who practices in Rio Arriba and Santa Fe counties and is a descendant of four generations of lawyers and judges. A simple concept that most Americans can grasp is "due process", Ms. Bull said, just as Mr. Lama and Mr. Balderas had been describing in their respective investigations. She said her colleagues who were cut off by the HSD were not afforded due process. Some of the audited providers could not even talk to clients they had worked with for many years, and they lost their businesses and their reputations that had taken many years to build. Ms. Bull said she is starting to let go of her Medicaid patients because she does not trust the state, Centennial Care or the managed care organizations (MCOs).

Trish Daino is a licensed independent social worker with nearly 40 years of service in the mental health field in four states. She has been a regional and county mental health coordinator, has worked with prisons and has been chair of a local health council for the past three years. Since the suspension of payments to two agencies in her community, there has been limited communication and care coordination, Ms. Daino said. There has been no community outreach by the Arizona agency that took over the provision of services and no contact with other private providers or the local health council. The county commissioners were unaware of the Arizona agency's presence in their community, and no information has been provided by state agencies. Private agencies are not taking new Medicaid clients because they fear the coming action.

Eleanor Van Inwegen worked for Valencia Counseling Services and stated that she is glad to see that this subcommittee is concerned about behavioral health. She said she has just one piece of advice: follow the money. "What happened to the $17.8 million that HSD got for the transition?" she asked. Employees with the new Arizona provider say they have not seen any dollars, and they were told that some would get new computers — but not everyone, because there was not enough money. The case files are locked up with no means of access, even with client authorization. The new providers did not address any mental health problems in treatment plans, just behavioral health, and Ms. Van Inwegen is concerned about nurses who are having to prescribe medication without background history on the client. This can be a waste of time and money and is harmful to the client.

Ed Church also worked for Valencia Counseling Services and was hired by Valle del Sol, which took over Valencia Counseling Services. He received an email directing employees not to talk to the press, he said, and no efforts were made in the community to introduce the new provider. The clinic went from six therapists to one full-time-equivalent (FTE) therapist serving 383 clients, Mr. Church said. A lot of the more stable clients have been given three- and four-month prescriptions, appointments have been canceled with no follow-up and rumors abound that only Medicaid and self-pay clients will be served. It is a crisis, he said, and what has been done is criminal.

Andres Paglayan works in information technology in the behavioral health industry and said he has now become an activist. He thanked subcommittee members for their efforts, saying

it seems like they are the only ones in government who care about what is going on. Clearly, there have been a lot of problems with services, he said, and he asked if anyone knew if the new agencies had been promised computers.

Hashem Faidi, a civil engineer with the Department of Transportation, has two autistic sons who were receiving services through TeamBuilders, which has now become Agave Health. His sons' services were cut in August, he said; Agave said it is hard to find providers. There were 60 children in the program, which provided after-school activities for two hours a day and for four hours a day during holidays. It was an excellent program, he said, and it now has been cut off. Mr. Faidi said he was very surprised to hear about fraud allegations against TeamBuilders and others, and he urged that the program be restored. His sons are on the waiting list for the developmental disabilities waiver, and the school-based program was great for them and for the family.

Anna Otero-Hatanaka, executive director of the Association of Developmentally Disabled Community Providers, said that many providers have concerns about what is going on with behavioral health, especially the negative impact of some persons "falling through the cracks". She is especially concerned about the validity of the allegations and the lack of due process or dispute resolution for the accused provider agencies. There is concern among her organization's members that Arizona providers could be brought in to take over developmentally disabled services, just as they were for behavioral health.

Questions/Concerns

Several subcommittee members expressed frustration with what they described as a lack of accountability for the Arizona providers. The more the subcommittee hears, the more it becomes evident that there are many problems with the behavioral health transition, one member commented. There have been significant layoffs, according to testimony, with Arizona agencies saying they cannot afford the employees. Their contracts were issued under an emergency provision, circumventing the Procurement Code, another member pointed out, and he asked the state auditor if he had noticed anything in the HSD contracts with the Arizona providers about requiring proof of financial responsibility. Mr. Balderas said that his auditors are examining the HSD procurement and contract compliance as part of the ongoing audit. Another member noted what appears to be a double standard: Arizona companies were handed contracts, certification and credentialing for their professional staffs, but now they are laying off people, claiming they do not have enough funds for providing services, yet New Mexico companies were told they had to provide the current level of services without getting paid.

There also was some discussion among members regarding HSD General Counsel Larry Heyeck's role in the AG's investigation. Mr. Lama assured members that Mr. Heyeck has no role in the AG investigation and will not be privy to any of the AG's findings prior to public release. Another member commented that it seems like legislators are being tested by state agencies and asked if these agencies are accountable.

Mental Health and Community Reentry Issues Among Rural Women in State Prisons

Cathleen Willging, Ph.D., senior research scientist at the Behavioral Health Research Center in Albuquerque, reported to subcommittee members the results of a recent study of 98 women incarcerated in a New Mexico state prison (see handout). In New Mexico, 45 percent of women prisoners are from rural communities. The purpose of the study, Dr. Willging said, was to identify needs for successful reentry of inmates into their communities. Eighty-five percent of the female prisoners screened tested positive for substance dependence; 50 percent screened were positive for current mental disorders; and 46 percent tested positive for both. Exposure to trauma was universal (100 percent), and 83 percent reported sexual trauma.

Dr. Willging presented three case histories to the subcommittee to illustrate the difficulties for female felons, all of whom had high hopes for their own reentries. The women had little knowledge of behavioral health resources, she said, and they needed to enhance their parenting skills. The assumption that family will provide support after a woman's release is faulty, Dr. Willging said. Lack of adequate housing and financial support render most women vulnerable to reincarceration, so there is need to intervene after the first incarceration. Many female prisoners suffer multiple substance dependencies and major depression and anxiety disorders, and there is a high level of stress about supporting their children on low-wage jobs. Incarcerated women receive few evidence-based instructions for what to do following release, Dr. Willging said. New Mexico spends a lot to keep women in prison and to support children while their mothers are in prison; it is a reactive rather than a preventive approach that prevails, she said.

Critical Time Intervention (CTI) is a national program that has been adapted for persons leaving psychiatric institutions, prisons and homeless shelters, Dr. Willging said. It is an evidence-based program that uses specially trained managers who emphasize issues that are crucial to rural women. In conclusion, Dr. Willging asked, is it better to give a woman $6,292 to help her transition back to her community or spend $40,000 a year to put her back in prison?

Questions/Concerns

There has been a spike in the female inmate population in New Mexico, one member noted, and the member wondered if Dr. Willging knew why. Dr. Willging said the spike is due to increased incarceration of women for drug abuse problems, and it has happened nationwide. Supported housing and vocational training are issues that should be considered for female inmates, another member offered. Dr. Willging agreed, noting that evidence-based reentry programs have a specific focus on the work force. Jobs and training have to be a priority in order to prevent recidivism, she said. Another member commented that components of the CTI program are considered Medicaid services in some states, and perhaps the CTI program could be made part of New Mexico's Medicaid plan, if the HSD would be willing to include it. The member suggested that the CTI program be put on the table when the full Legislative Health and Human Services Committee meets to consider recommended legislation.

Another member who represents 19 chapters of the Navajo Nation said molestation and

alcohol abuse are huge concerns for Navajos. Education is needed, she said, and it is difficult to get tribal jurisdictions to do it. Gaming compacts are now under negotiation, and it would be good to access some of that revenue to pay for this kind of education.

Integration of Behavioral Health and Primary Care for the Seriously Mentally Ill

Cory Nelson, deputy director of the Arizona Department of Health Services (DHS), described Arizona's new approach to integrating behavioral health with physical health care (see handout) through a collaborative approach between the state Medicaid agency and the DHS. Instead of integrating behavioral health into physical health, Arizona is carving physical health services into behavioral health for this small subset of the population, Mr. Nelson said. The seriously mentally ill (SMI) population dies from chronic medical diseases at a much earlier age than the general population, he pointed out, and 60 percent of Medicaid's highest-cost beneficiaries with disabilities have co-occurring physical and behavioral health conditions. In 2013, the DHS received a CMS waiver that allows one entity to be entirely responsible for the SMI population. Arizona Health Care Cost Containment System is the single state agency that contracts with the DHS as the MCO for behavioral health. The DHS, in turn, contracts with four regional behavioral health authorities and with six Native American tribes that operate as tribal regional behavioral health authorities.

Planning for the new model, Mr. Nelson said, involved a two-year process of building a relationship between the state Medicaid agency and the behavioral health provider community. The DHS started with an executive steering committee that met biweekly so that top executives could learn to cooperate from the top down, he said. The DHS also went out into the community for input and made certain that the process was totally transparent and that all decisions were posted on the agency web site in real time. The committee spent several months drafting a request for proposals for the MCOs, he said. There were five bidders, and the winning bidder continued to use the existing behavioral health networks and focused on integrated clinics where behavioral health and primary care were available at the same site. It is a single-payer health care portal, and the winning agency had gone out into the community for help with writing its proposal.

Anticipated benefits of the new health care model for the SMI population, in addition to better cost containment, include overcoming disparities through integrated care, screening, prevention, early intervention, education and helping the SMI individuals lead more productive lives, Mr. Nelson said.

Questions/Concerns

Several members of the subcommittee had questions for Mr. Nelson about New Mexico's HSD and whether its managers had spoken with him about Arizona's behavioral health model. Mr. Nelson said that they had not. Another member asked Mr. Nelson if he was familiar with the Arizona providers that were brought into New Mexico by the HSD. Mr. Nelson said that he was aware that these entities did provide services in Arizona, but he was not personally familiar with their work. Another member urged subcommittee members to note that in Arizona, Native

American tribes are state contractors in the behavioral health system.

Local Perspectives on Funding for Indigent Behavioral Health

Jolene Schneider, executive director of Four Winds Recovery Center in Farmington, told subcommittee members that San Juan County continues to have severe problems due to substance abuse, including methamphetamine use among juveniles. During the last year, the population in detoxification programs was 3,500, 90 percent of whom were Native American, she said. There were 224 individuals admitted into residential treatment, and over half of these individuals were Native American, Ms. Schneider said. Currently, Four Winds Recovery Center, which was founded in 1979, operates with 37 FTE staff on a budget of $1.7 million. Seventy-five percent of referrals to Four Winds Recovery Center are court-ordered, Ms. Schneider said, and nearly all individuals are low- or no-income clients, and Medicaid does not cover these services. The San Juan Indigent Care Fund provides $404,000 to the center annually, she said, and loss of these funds would result in the closure of the protective custody detoxification program, the loss of treatment beds and an increase of up to five months that individuals spend on the waiting list.

Lauren Reichelt, director of health and human services for Rio Arriba County, told members that Rio Arriba County is the first county in New Mexico to create its own health and human services department in response to the substance abuse epidemic there. The county looked at statistics of who was entering the hospital emergency room, who was in the county jail and who required the highest cost of care. The county found that the vast majority of these individuals were there because of substance abuse or mental illness. Rio Arriba County has adopted a care coordination model using outcome-based measures, i.e., babies born at greater than five pounds and without addictions, and their program now has become a national model. The county gross receipts tax, plus an additional mill levy, is very important to the program, Ms. Reichelt said, with the indigent fund providing $564,000 annually. If the county has to ask taxpayers for another tax to replace this one, citizens might fear another intercept, she said. One of the aims of the federal Patient Protection and Affordable Care Act is to empower local solutions, Ms. Reichelt said, and Rio Arriba County has an excellent health council that is working to develop an affordable housing plan in response to the needs of the homeless. The local hospital had 318 admissions directly related to substance abuse, but any savings created for the hospital stay with the hospital.

Ms. Reichelt said she also wanted to address the loss of behavioral health services in the community, which has seen a reduction in services. Losing infrastructure will reduce the level of service in Rio Arriba County. Ms. Reichelt said she is currently co-located with the Espanola Public Health Office and El Centro in a central location with a state-of-the-art treatment center that promotes care coordination and maximizes grant application opportunities. There is great concern about large organizations coming in from out of state to provide care that is already being provided locally.

Robert Mitchell, administrator of the San Juan County Alternative Sentencing Division,

described three different programs — probation services for magistrate courts, jail-based driving while intoxicated (DWI) treatment and jail-based 60-day methamphetamine treatment — and "a lot of investment" by the community in these special populations. The DWI program population is 76 percent Native American, and the methamphetamine program has an entirely female population, driven by the high number of children in protective custody. Visitation is tied to family programming, Mr. Mitchell said, and last year there were 185 family members involved in more than 400 treatment episodes. This is why the indigent fund is so important, because Medicaid and private insurance stop after an individual is incarcerated. The indigent health care fund pays for 30 percent of these two programs, Mr. Mitchell said, and the programs would end without this funding.

Kristine Carlson, a licensed independent social worker, is program and clinical administrator of Totah Behavioral Health Authority. There are "huge issues" with alcohol and substance abuse among the population served by her organization, which utilizes traditional mental health services, Diné healing and traditional medicine men and women. In a collaboration among the city, tribal government and county government, the program is focused on getting people out of the hospital emergency room and/or jail and, through joint-intervention intensive rehabilitation, into housing and employment. Thirty-two percent of the funding comes from the county indigent fund, Ms. Carlson said, which provides funding for traditional services. Ms. Carlson said that the program has a high success rate in the first three months and provides a huge savings to the county. The local collaborative has worked very hard to provide a continuum of care, she said.

County Detention Health Care Costs

Grace Phillips, attorney with the New Mexico Association of Counties, presented information (see handouts) about detention costs, design bed capacity and the average daily population in New Mexico detention facilities, broken down by county. On any given day in New Mexico, there are more people in county jails than in the state corrections system, Ms. Phillips said. She also provided a copy of several New Mexico Sentencing Commission reports, one on length of stay and the other on the effect of a mental health diagnosis on the length of stay. The length of stay has increased over time, and the current median length of stay is 140 days for those held but never sentenced. Twenty percent of inmates are already on a mental health caseload in Bernalillo and Dona Ana counties, and a psychotic diagnosis will increase the length of stay in jail to an average of 290 days, she said. The more serious the mental disorder, the longer that individual will stay in jail. There is frustration that the county detention centers have a population that really should not be there in the first place, Ms. Phillips said.

Questions/Concerns

One subcommittee member commented on the disparities in revenues and offsets in Ms. Phillips' charts. Most of the disparity between Bernalillo County and any other county is due to revenue that comes from housing federal inmates, Ms. Phillips said. Luna County has a 400-bed facility, but the majority of those bed spaces are sold to the U.S. Marshals Service. Santa Fe County also sells bed spaces and houses state inmates and federal prisoners. Another member

commented that the current system of jails has become big business. The member said that he had just read a report indicating that Native Americans spend more time in jail for the same crime than others do, and he feels a lot of the revenues are from housing Native Americans who come from the federal system. Native Americans just sit there because no one is paying any attention, the member asserted. This chart just reflects dollar amounts, he said to Ms. Phillips, but it does not show the cost of taking someone's freedom. He asserted that if society spends more money on building jails than on its children, then there is a problem.

Update on the HSD's Fiscal Year 2015 Budget Request for Behavioral Health

Greg Geisler, principal analyst with the Legislative Finance Committee (LFC), said that the HSD's budget request for fiscal year (FY) 2015 is $5.8 billion from all revenue sources, an increase of $394 million, or 7.3 percent, from the FY 2014 budget (see handout). The FY 2015 total Medicaid budget for physical health is $4.2 billion, Mr. Geisler said. FY 2015 will be the first year of Medicaid expansion paid for by the federal government, anticipated to exceed $400 million for 60,000 newly eligible adults. The HSD is projecting savings of $15.3 million of the $42 million base general fund support of behavioral health services due to 15,000 clients being covered by Medicaid starting in 2014 with 100 percent federal revenue, Mr. Geisler said. However, the HSD is proposing to reallocate the majority of these savings, $12.1 million, as an expansion request for other purposes, including enhancing non-Medicaid services, value-added services and audit and compliance. Key questions to the HSD in the LFC report included the following:

- data to support anticipated savings;
- the rationale for adding five employees to the audit and compliance unit and how this unit will mesh with MCOs and behavioral health contractor oversight;
- more detail of plans for $3 million for technical services and training for provider agencies and $4 million to enhance non-Medicaid services; and
- more information about the proposed $3.5 million for value-added services, including $2.5 million for transitional living services and $1 million for the behavioral health phone crisis line. The LFC is seeking more detail about the phone line and the funding history, sources and planned service levels for transitional living.

In summary, Mr. Geisler said, the HSD is proposing a major restructuring of the BHSD budget and an expansion of its staff. The substance abuse strategy proposed by the HSD is weighted toward intensive outpatient services, but network issues are an obstacle, according to the report. State and local governments will continue to bear the cost burden of inpatient or residential programs for adults. The LFC report advised that the state should optimize opportunities for Medicaid support for both physical and behavioral health.

Questions/Concerns

Mr. Geisler was asked about the $68 million pool for uncompensated care, which is less than the previous sole community provider funding. The HSD wants to intercept the one-eighth tax increment from the counties. Keith Gardner, chief of staff for the governor, who was in attendance, said he is looking for a consensus proposal. The final proposal definitely will come

before the legislature in the upcoming session, Mr. Gardner said.

A member asked about the $17.8 million that was transferred to the HSD from the general fund to pay the new Arizona behavioral health services providers. In August, the HSD applied for a budget adjustment request, so the funds have already been transferred, Mr. Geisler said, adding that the HSD has heard that it is approaching the maximum amounts that can be spent on these contracts, and it wants the new providers to start billing Medicaid. There does not appear to be any request for continued funding for the Arizona providers, Mr. Geisler noted. Another member asked if anyone knows what amount is "in the bucket" that OptumHealth is holding for services that have not been paid for. Mr. Geisler said that the HSD claims that the $18 million from the general fund will be offset from what OptumHealth has been accumulating. Another member questioned the need to add five more auditors to the compliance staff of 37 at the HSD.

Approval of Minutes

A motion was made to approve the minutes from the September 30 meeting of the subcommittee. A member pointed out an error in the second paragraph of page 3, where the words "Centennial Care" should be replaced by "Native Americans" regarding fee-for-service. The motion was seconded and passed unanimously with the above change.

Marijuana as Harm Reduction

Jessica Gelay, policy coordinator for the Drug Policy Alliance, presented information to the subcommittee about the use of medical marijuana as harm reduction (see handout). Ms. Gelay said that there are now nearly 9,000 registered users of medical marijuana in New Mexico, and described the use of marijuana as an alternative for prescription psychotropic drugs, which are often accompanied by significant side effects. The Drug Policy Alliance calls for the nonjudgmental, noncoersive provision of services and resources to people who use medical marijuana to assist them in reducing attendant harm. Marijuana use can help with physical symptoms of chemical withdrawal by dampening receptor signals for craving, Ms. Gelay said. It can also reduce seizures, and the risk of overdose and dependence is less than with other drugs. Consider that marijuana has been misclassified, she said, and that it should be added to the pharmacopeia of use as a drug. Ms. Gelay said she brought several clients with her to today's presentation in order to put a human face on these issues.

The Reverend Gerald White, a retired Methodist minister, and his wife, Judy, described the long journey of their brain-injured adult son and how, after many years of taking various pharmaceuticals, they found that marijuana obviates the need for prescription drugs, which have significant side effects, and gives him relief from other symptoms, such as seizures. It was actually his psychiatrist who recommended that he try marijuana, Mrs. White said. The Whites are hoping the state will expand approval of medical marijuana as a treatment for traumatic brain injury, as well as for Parkinson's and Huntington's diseases.

Tim Origer is a Vietnam veteran and amputee with significant phantom pain. Mr. Origer

said that after years of using unsatisfactory prescription drugs, he applied for medical marijuana so that he could have a drug to use only when he needed it. He now does advocacy work with other veterans and said he would like to see the stigma removed from medical marijuana so there could be more access for other veterans who need it.

Questions/Concerns

A subcommittee member thanked the presenters for telling their stories and agreed that years of use of psychotropic drugs comes with significant risks of side effects. Dave Schmidt, who also works with Ms. Gelay at the Drug Policy Alliance, told subcommittee members that the Department of Health medical advisory board will be meeting the following day and will vote on whether to add traumatic brain injury and Parkinson's and Huntington's diseases to the list of approved uses for medical marijuana. The board's action will then go to the secretary of health, who will make the final decision. Another member asked about the current status of the law, and Mr. Schmidt described an impending shortage of producers. There are now 9,000 individuals approved for medical marijuana, he said, and the number of producers needs to be increased to meet demand without driving people into the black market. Issues with medical marijuana and the developmental disabilities waiver (the federal government still considers marijuana to be illegal) are ongoing, Mr. Schmidt said, and it might be worthwhile to look at how other states are handling this issue.

Public Comment

Patricia McKeen, a mental health counselor with New Awakenings in Albuquerque, told subcommittee members that she feels there are huge capacity issues in the transition into Centennial Care. The only counselors who will be reimbursed for services under Centennial Care are licensed professionals, she said she was told by Magellan, who manages these services for Presbyterian Medical Services. New Awakenings has been serving hundreds of clients and previously was reimbursed under OptumHealth. A subcommittee member said she would look into this issue.

Nat Dean has a brain injury from an automobile accident and has been on medication for years. Medical marijuana not only works for her, but provides a milder form of treatment. It has reduced her doctor visits, and, Ms. Dean said, she is no longer addicted to narcotics. The New Mexico program is tightly regulated and provides access to having the cannabis tested so she knows exactly what is in it, and she can buy a strain that is not psychoactive.

David Olson said he has used Medicaid and received medical and behavioral health services, but with no case management, the state was spending twice as much as needed. Modern psychotropic drugs can be very helpful, he said, but the majority of people who take them suffer more harm than good. Diagnoses are not consistent and can vary from provider to provider, Mr. Olson said.

Adjournment

There being no further business, the fourth meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee for the 2013 interim adjourned at 5:30 p.m.